STATE OF MARYLAND

DHMH

Maryland Department of Health and Mental Hygiene
Developmental Disabilities Administration (DDA)
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Martin O'Malley, Governor – Anthony G. Brown, Lt. Governor – Joshua M. Sharfstein, M.D., Secretary

Contribution to Cost of Care Interim Procedural Changes Frequently Asked Questions (FAQs)

Version 3 – Updated 5/19/2014

The answers provided in this document represent the current guidance from the Developmental Disabilities Administration (DDA) to providers regarding Contribution to Cost of Care. Until further information is distributed, please follow the provided guidance.

FREQUENTLY ASKED QUESTIONS

1) What is Contribution to Cost of Care?
    a) Post eligibility treatment of income is the formal terminology used in federal regulations for Contribution to Cost of Care (CTC/COC). In accordance with 42 CFR §441.303(e), calculation of CTC must be completed when the state, Maryland, furnishes waiver services to individuals in the special home and community-based waiver group, known as the optionally eligible group under 42 CFR §435.217. The post-eligibility calculation of CTC determines the amount (if any) Medicaid reduces its payment for services that are furnished to optionally eligible individuals. As a result, the post-eligibility calculation of CTC is the amount (if any) for which an individual is responsible to pay for their waiver services costs.

2) How do room and board costs relate to cost of care?
    a) Room and board costs have often been confused with CTC. However, they are two distinct cost categories. Room and board (representing rent and food) are not reimbursed by Medicaid as they are personal living expenses and the individual is responsible for these costs. Even though room and board payments and payments for CTC are collected together by the residential provider, payment for room and board costs go towards rent and food costs, while the payment for CTC goes towards the individual's DDA waiver services costs.
    b) The DDA waiver limits the amount a provider may charge for room and board costs to $375. This means an individual cannot pay more than $375 in total towards room and board.
    c) Whether individuals need to contribute to their cost of care is based on their eligibility for the DDA's Medicaid waiver. Individuals who are categorically eligible for the DDA do **not** have to contribute to the cost of care. The eligibility letter (sent from the Department's

Eligibility Determination Division, "EDD") determines eligibility status and their contribution to your cost of care.

3) Is the "Net Contribution" in PCIS2 the cost of care?
    a) On line 19 and line 27, net contributions that are $375 or less represent only room and board costs. Net contributions greater than $375 reflect the sum of room and board and CTC, where the amount over $375 reflects the cost of care.
    b) For example:
        (1) An individual has a calculated net contribution of $600. Room and board costs equal $375, and CTC equals $225.
        (2) An individual has a calculated net contribution of $100. The individual pays $100 for room and board, while the DDA funds the provider $275 to make up the difference between the maximum room and board ($375) contribution and the individual's payment ($100). DDA funds the $275 with state-only funds as part of the quarterly payment process. In this example, nothing is paid toward Cost of Care.

4) Can you clarify the interim procedures for manually adjusting the PCIS2 Consumer Contribution form?
    a) Interim procedures for using the PCIS2 Consumer Contribution form differ, depending on the individual's eligibility category:
        i) For **categorically eligible** and **ineligible** individuals:
            (1) Complete the PCIS2 Consumer Contribution form as you historically have (prior to January 1, 2014).
            (2) Review line 19 or line 27.
                a. If the amount is $375 or less, then no further action is required.
                b. If the amount is greater than $375, then adjust line 18 or 26 so that line 19 or 27 is equal to $375.
        ii) For **optionally eligible** individuals:
            (1) Complete the PCIS2 Consumer Contribution form in accordance with provided guidance
    b) The interim procedures listed above were effective January 1, 2014 and remain effective until further notice. In the April 3rd memo from Patrick Dooley, the April 1, 2014 effective date was referenced to communicate to providers that the calculation of CTC will not transition to the Eligibility Determination Division (EDD, formerly DEWS) on April 1st, as had been previously communicated by DDA.

5) What if a negative number is calculated on line 19 or 27 in the PCIS2 Consumer Contribution form?
    a) This should not be possible in PCIS2. Please contact the DDA helpdesk to investigate the issue if line 19 or 27 is calculated as negative. If PCIS2 returns $0 for the net contribution, nothing should be collected from the individual.

6) What is a Medicaid coverage group and how is an individual's eligibility category determined?
    a) Maryland's Eligibility Determination Division (EDD) determines an individual's Medicaid coverage group and eligibility category using complex federal and state guidelines and

formulas. It is important to note that the type of income a person receives is not the sole determinate of waiver eligibility. The DDA website has some information on eligibility determination that you may find useful. Please follow the link below: https://mmcp.dhmh.maryland.gov/SitePages/Medicaid%20Coverage%20Groups.aspx

i) Waiver Coverage Groups "H01" and "S01" are optionally eligible.
ii) All other waiver coverage groups are considered categorically eligible.
iii) No waiver coverage group means ineligible or non-waiver.

7) What if a provider believes that a participant's Medicaid coverage group or eligibility category is incorrect?
   a) The provider or the resource coordinator should contact the participant's eligibility case worker or resource coordinator to investigate and follow up with the Eligibility Determination Division (EDD).

8) Providers often do not know who the individual's eligibility case worker is. Can providers receive a list of which caseworker at EDD is assigned to which individuals, in order to contact them with questions about specific issues?
   a) Yes, as of 1/29/2013 workload is distributed as follows:

Case Manager	Assignment	Phone Number
Michael Edmonds	A – E	(410)767-6619
Susan Davis	F – J	(410)767-6622
Gabrielle Kelly	K, L. O, Ra-Rh, and Sa-Si	(410)767-6563
Nita James	M, N, P, Q, and Ri-Rz	(410)767-6627
Othille Henry	Si-Sz and T thru Z	(410)767-6611

9) What if a provider is unsure of an individual's eligibility category?
   a) Each DDA residential provider agency received a list of their residential service participants with their corresponding waiver coverage group and eligibility category. This list was sent to the agency's Executive Director, Director or other contact(s) on file with DDA. Agency employees should check with the DDA contacts at their agencies to obtain their residential list.
   b) If you do not know an individual's eligibility category, please contact the DDA Helpdesk or the individual's eligibility case worker.

10) Do ineligible individuals have to contribute to their cost of care?
   a) Contribution to cost of care is only applicable to optionally eligible individuals in the waiver, and currently there is no legal authority for Maryland to apply contribution to cost of care to individuals with state-only funding. Therefore, at this time, DDA will not collect income from individuals who are not enrolled in the waiver.
   b) Only collect room and board from ineligible individuals if there is a provider agreement with an individual that provides that they will pay a specific amount for cost of room and board.
   c) Going back to January 1, 2014, providers should return collected CTC funds to ineligible individuals and update PCIS2 accordingly, based on the following two scenarios:

   i) If there was a provider agreement in place with the individual, then the provider should return funds collected in excess of room and board, as specified in the provider agreement.
   ii) If there was no provider agreement in place with the individual, then the provider should return all funds back to the individual.
d) If the PCIS2 CTC form is locked, please submit an error update prior to the 1st quarter payment.
e) DDA is in the process of developing policy and regulations regarding non-waiver individuals including guidance on collecting contribution to cost of care.

11) For ineligible individuals, if no provider agreement exists, can a provider construct one and is there guidance on how to construct one?
   a) These agreements are executed at the provider's discretion. Please work with other providers and provider organizations to identify best practices.

12) Should all DDA residential participants have a provider agreement in place?
   a) The DDA waiver in Appendix I-6 states that, "Waiver providers are expected to bill waiver participants for room and board expenses. Upon enrollment in the program, waiver providers sign an agreement that states that room and board costs are not included in Community Pathways waiver rates and waiver participants will be billed for room and board costs. The charge cannot exceed $375 monthly."
   b) As a best practice, it is recommended that providers have a provider agreement in place with residential participants.

13) What changes do residential participants have to report to EDD? How are these submitted?
   a) Continue to send medical and remedial care expenses to EDD.
      i) When sending this information please use Form OES-001, "Request for Non-Covered Services." You can find this form at: https://mmcp.dhmh.maryland.gov/longtermcare/docs/OES-001.pdf
   b) As outlined in an individual's eligibility letter, changes that affect an individual's eligibility, such as changes in income and assets, must be reported to the participants EDD eligibility case worker within ten (10) days of the change.
      i) When submitting this information to EDD, please use Form DHR/FIA 491, "Change Report Form." You can find this form at: http://dhr.maryland.gov/documents/SHINE/SHINE%20Forms/Change%20form.pdf
   c) When reporting changes, information should be sent by mail to EDD on a person-by-person basis with the attached forms, and evidentiary documentation.
   d) The address to submit information to EDD is:
      DHMH Eligibility Determination Division
      6 St. Paul Street, Suite 400
      Baltimore, Maryland 21202

14) If we receive an eligibility letter from EDD that has a different amount for cost of care than the net contribution amount calculated in PCIS2, which amount do we collect?

a) For optionally eligible individuals:
   i) If EDD Calculated Cost of Care + $375 is greater than the net contribution calculated using the PCIS2 form do not adjust the PCIS2 form. Collected the net contribution calculated by PCIS2.
   ii) If EDD Calculated Cost of Care + $375 is less than the net contribution calculated using the PCIS2 form, adjust line 18 or 26 so that the net contribution equals the EDD Calculated Cost of Care + $375. Collect the net contribution calculated by PCIS2 after the adjustment.

15) Does an individual still have a personal needs allowance?
   a) While DDA works to transition to a new process, the current Consumer Contribution form in PCIS2 is still in use. Therefore, the personal needs allowance will still be applied. Historically, the personal needs allowance was calculated by taking the current Social Security Income Federal Benefit Rate and subtracting the cost of room and board, $375. Since SSI FBR changes on the calendar year, you will see a change in the personal needs allowance starting in January. For calendar year 2014, the personal needs allowance is calculated to be $346 (= $721 - $375). PCIS2 has been updated and will reflect this new PNA until additional guidance is provided.

16) If an individual receives less income than the FBR SSI, do we collect the full $375 for room and board costs or does their personal needs allowance get applied first?
   a) Until DDA fully implements new CTC procedures, DDA will allow these individuals to maintain a PNA and have reduced room and board costs, aligning? Aligned? with the PCIS2 Consumer Contribution form. In other words, DDA will fund the provider the difference using state-only dollars. This funding will be included in the provider's quarterly prepayments.
   b) Until further notice, only collect what is calculated by PCIS2 based on the interim procedures outlined in #4.

17) What is the definition of medical and remedial care expenses?
   a) According to federal regulation, 42 CFR §435.726, eligible medical and remedial care expenses are amounts for incurred expenses for medical or remedial care that are not subject to payment by a third party, including:
      i) Medicare and other health insurance premiums, deductibles, or coinsurance charges; and
      ii) Necessary medical or remedial care recognized under State law but not covered under the State's Medicaid plan, subject to reasonable limits the agency may establish on amounts of these expenses.
   b) More guidance will be forthcoming on these expenses and how to apply deductions.

18) Is there a way currently that medical and remedial expenses can be deducted?
   a) The current PCIS2 Contribution to Care form does not allow for the deduction of medical and remedial care expenses. However, if an individual has earned income, the costs of insurance premiums can be deducted using line 10, "Expenses and Premiums."

b) Categorically eligible and ineligible individuals will not contribute to their cost of care and consequently deductions are not applicable for these individuals. For these individuals, net contribution amounts calculated in line 17 or 29 represent only room and board costs.

19) If we collect a Representative Payee fee from an individual, are we able to exclude these fees from the calculation of their income before calculating the room and board and/or CTC amount, or are these fees paid from the Individual's PNA funds?
    a) Representative Payee fees are not an eligible deduction under federal waiver regulations and must be paid from the Individual's personal use funds.

20) Should we continue to try to collect net contributions from individuals who have not paid in full each month prior to this change?
    a) If on January 1, 2014 the individual's contribution under the policy outlined in #4 would be limited to the lesser of the net contribution to care or $375, then you may not collect in excess of what is due for room and board ($375).

21) What if the provider is unable to collect funds from individuals?
    a) Prior year uncollectible funds may now be reported on a provider's cost report for reimbursement by DDA through the end of the year reconciliation.
        i) To substantiate uncollectable funds, the provider should provide the following documentation that demonstrates concerted attempts to collect funds from the individual and the refusal or lack of funding for the individual to pay the provider. This documentation includes but is not limited to the following:
            (1) Communications to/from the individual's representative payee;
            (2) Communications to/from the Social Security Administrations; and
            (3) Communications to/from the individual's family or advocates
    b) Until the new PCIS2 form is implemented, if an individual has a net contribution less than $375, the provider should maintain documentation of why this is the case.

22) Providers will now collect significantly less from individuals. What will be the source of funding for that difference in collections?
    a) Procedures will be cost neutral for providers. The DDA will be providing the difference in calculated net contribution.

23) If an individual resides in a HUD home, how is the collection of room and board treated? Is there a deduction for the HUD subsidized rent?
    a) There is no deduction for rent, including HUD-subsidized rent. Medicaid does not reimburse for room and board costs, and the waiver limits the amount a provider may collect for room and board cost to $375.
    b) DDA has constructed a spreadsheet for providers who would like assistance computing the amount they can collect from their residential providers. You can find the document on the DDA website under the "providers" tab.
        i) Residential providers that have individuals who pay HUD subsidized rent to a 3rd party may not be able to collect the full net contribution amount.

c) More guidance will be forthcoming on HUD specific issues.

24) For service providers that provide Individual Family Care services, how will the new contribution to cost of care calculation affect their current procedures for collecting from individuals?
   a) At this point, there have been no changes that affect current processes or contracts. More guidance will be forthcoming.

25) Do providers still have to report to SSI?
   a) Yes, the requirement to report to SSI remains in effect.

26) A number of residential participants will have significantly less income collected that may result in their resources reaching or exceeding the Medicaid resource limit of $2,000. Will DDA provide any guidance on how to spend down money?
   a) Individuals may consider a special needs trust, or fall within special groups with higher resource amounts such as Employed Individuals with Disabilities Program (EID). For more information, please see: http://www.mdod.maryland.gov/Employment%20and%20Training.aspx?id=534

27) When did the new Contribution to Cost of Care procedures go into effect?
   a) As of January 1, 2014, interim procedures were in effect as previously communicated by DDA.